SECTION V - ELIGIBILITY REQUIREMENTS

V. ELIGIBILITY REQUIREMENTS

In order to be eligible to elect hospice care as a Medicaid benefit, an individual must be entitled to Medicaid benefits and be certified as being terminally ill. "Terminally ill" is defined as having a medical prognosis that life expectancy is six months or less. Additionally, those medically indigent persons who are terminally ill and who would be Medicaid eligible if institutionalized may also qualify for hospice benefits.

A. Application for Medicaid Benefits

The medically-indigent individual who is not currently a Medicaid recipient, but who has been certified as being terminally ill and has requested the hospice service, may apply for Medical Assistance benefits at the local office of the Department for Social Insurance in the individual's county of residence. An interested party may apply on behalf of the individual.

A completed and signed copy of the Election of Medicaid Hospice Benefits form, MAP-374, will need to be presented to the local office at the time of application.

B. Duration of Benefits

Effective 1/01/89, there is no limit on the number of days a patient may receive hospice care.

~~[The hospice care benefit consists of two 90-day periods and one subsequent 30-day period (referred to as election periods).~~

~~An additional 60-day period may be authorized, if necessary.]~~

C. Certification of Terminal Illness

The hospice must obtain the certification that an individual is terminally ill in accordance with the following requirements:

1. ~~[For the first 90-day period of hospice coverage, t]~~The hospice must obtain, no later than 2 calendar days after hospice care is initiated, written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician if the individual has an attending physician.

~~[2. For the subsequent 90-day or 30-day periods, the hospice must obtain, no later than 2 calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group.]~~

2[~~3~~]. The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six months or less and the signature(s) of the physician(s) required to certify the terminal illness. The hospice maintains the certification statements.

3[~~4~~]. An individual who is eligible for Medicare hospice benefits must elect to use the Medicare benefits as the primary source of payment [~~before Medicaid coverage begins~~]. The date Medicare eligibility begins must be entered on the Election of Medicaid Hospice Benefits Form (MAP-374). [~~If the individual elects to have t~~]The KMAP may make co-payments for drugs and/or respite care [~~the Medicaid covered benefit periods will begin with the date of election and each day will be counted against the total number of Medicaid benefit days whether or not Medicaid made payment for those days~~].

4[~~5~~]. For an [~~An~~] individual who is eligible for both Medicare and Medicaid benefits and [~~,~~] who resides in a long term care facility, [~~and who wishes~~] room and board charges may [~~to~~] be paid by Medicaid. [~~, must elect to use the Medicare and Medicaid Hospice Benefits concurrently~~.]

D. Election of Hospice Care

1. If an individual who meets eligibility requirements for hospice care elects to receive that care, an Election of Benefits Form (MAP-374) must be completed by the individual or the individual's representative who is, because of the individual's mental or physical incapacity, authorized in accordance with state law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill individual.

~~[2. The two 90-day election periods must be used before the 30-day period.]~~

2[~~3~~]. An election [~~period~~] to receive Medicaid hospice care will be considered to continue indefinitely [~~through the initial election period and through the subsequent election periods~~] without a break in care, as long as the individual remains in the care of the hospice and does not revoke the election in writing. (Revocation of Medicaid Hospice Benefits Form, MAP-375)

3[~~4~~]. The individual or representative may designate an effective date for the election that begins with the first day of hospice care or any other subsequent day of hospice care. The individual may not designate an effective date that is earlier than the date that the election is made.

4[~~5~~]. An individual waives all rights to Medicaid benefits for the duration of the election of hospice care for the following services:

a. Hospice care provided by a hospice other than the hospice designated by the individual (unless provided by arrangements made by the designated hospice).

b. Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected except for services provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

5[~~6~~]. The election statement includes the following:

a. identification of the particular hospice that will provide care to the individual

b. the individual's (or representative) acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care as it relates to his or her terminal illness

c. acknowledgement that certain Medicaid services are waived by the election of hospice care

d. the effective date of the election

e. the signature of the individual or representative.

6[~~7~~]. A copy of the election form for all clients who elect hospice coverage must be forwarded to the Department for Medicaid Services and to the local Department for Social Insurance Office.

E. Revoking Election of Hospice Care

An individual (or representative) may revoke the election of hospice care at any time during the benefit [~~an election~~] period.

1. To revoke the election of hospice care, the individual (or representative) must complete the Revocation of Hospice Benefit, form MAP-375, and file with the hospice. A copy of this form must be submitted to the Department for Medicaid Services and to the local Department for Social Insurance Office.

2. Upon revocation of the election of Medicaid coverage of hospice care, the individual is no longer covered by Medicaid for hospice care, but if eligible, may resume Medicaid coverage under the regular scope of benefits. The individual may at any time elect to receive hospice coverage for any other benefit periods he or she is still eligible to receive.

F. Change of the Designated Hospice

An individual (or representative) may change the designation of the particular hospice from which the hospice care will be received [,] once.[~~in each election period~~.]

1. The change of the designated hospice is not a revocation. [~~of the election period for which it is made~~].

2. To change the designated hospice provider, the individual (or representative) must complete form MAP-376, Change of Hospice Providers, and file with the hospice from which care has been received and with the newly designated hospice.

   A copy must also be forwarded to the Department for Medicaid Services and to the local Department for Social Insurance Office.

G. Inactive Status

A lapse in the hospice benefit [~~period~~] is allowed if the patient's condition improves to an extent that active hospice services are temporarily unnecessary. If [~~at the end of the first or second benefit period~~,] the patient's condition has improved, the patient may be placed in inactive status by the hospice agency [~~and the remaing benefit period(s) may be saved~~] until the patient's condition once again requires active hospice services. [~~At the end of the third benefit period, if the patient's condition is such that he/she may be placed in "inactive" status, the 60 day extension of the Medicaid Hospice Benefit may be saved for a later time.~~]

No hospice services (including room and board or bed reservation days) may be billed for any patient in inactive status. The patient may revert to regular Medicaid benefits; however, since Medicaid eligibility for hospice patients is determined using a special income standard, some patients may not be eligible for Medicaid benefits during inactive status.

The Termination of Medicaid Hospice Benefits Form (MAP-378) or the Hospice Patient Status Change Form (MAP-403) must be used to notify the Department for Medicaid Services that the patient is entering inactive status.

When the patient returns to active status, a Hospice Patient Status Change Form (MAP-403) [~~a copy of the original election form MAP-374 with the second or third certification area~~] must be completed indicating the date that the patient will be in active status and must be sent to the Department of Medicaid Services and the local Department for Social Insurance Office and the patient will be again added to the hospice file.

[~~H. Extension of Hospice Care Beyond Three Benefit Periods~~

~~At the end of the final 30-day benefit period, the KMAP will consider an extension of the hospice care benefits for up to sixty consecutive (60) days. The extension is to be requested by submission of the form, MAP-377, Request for Extension of Medicaid Hospice Benefits. This form requires a statement from the Hospice Medical Director that the patient's life expectancy is 60 days or less. Patients who have been in inactive status are also eligible for the 60 day extension and that period may be saved for as long as necessary.~~

~~The request for extension must be received by the Department for Medicaid Services, five days prior to the end of the 30 day benefit period.~~]

H[~~I~~]. Termination of Hospice Care

[~~1. If hospice care is terminated because covered days have been exhausted, a Termination of Medicaid Hospice Benefits form MAP378) must be completed. A copy must be submitted to the Department for Medicaid Services and to the local Department for Social Insurance Office.~~]

1[~~2~~]. Notification of Death

The hospice agency is required to notify the Department for Medicaid Services of the death of a recipient no later than two (2) days following the death. Additionally a Termination of Medicaid Hospice Benefits Form (MAP-378) must be completed. A copy must be submitted to the Department for Medicaid Services and to the local Department for Social Insurance office.

2[~~3~~]. Inactive Status

The hospice agency is required to notify the Department for Medicaid Services within two working days if the patient goes into inactive status using the Termination of Medicaid Benefits Form (MAP-378) or the Hospice Patient Status Change Form (MAP-403). [~~The date the patient became inactive must be entered and the section marked "Other" must be completed indicating "inactive" status~~.]

SECTION VII - REIMBURSEMENT

On any day on which the recipient is not an inpatient, the hospice is paid the routine home care rate unless the patient receives continuous care. The hospice payment on a continuous care day varies depending on the number of hours of continuous services provided. The continuous care rate is divided by 24 to yield an hourly rate. The number of hours of continuous care during a continuous home care day is then multiplied by the hourly rate to yield the continuous home care payment for that day. A minimum of eight hours of care must be provided on a particular day to qualify for the continuous home care rate.

On any day on which the recipient is an inpatient in an approved facility for inpatient care, the appropriate inpatient rate (general or respite) is paid depending on the category of care. The inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate is paid.

Payment for inpatient respite care may not be for more than 5 consecutive days; payment for the sixth and any subsequent days of inpatient respite care is made at the routine home rate.

If the recipient dies while an inpatient, and is discharged deceased, the inpatient rate (general or respite) is paid for the discharge day.

For recipients residing in a skilled nursing or intermediate care facility payment for room and board for each day is made in addition to the payment for routine home or continuous home care for that day. (In the case of continuous care, the hospice agency must go into the long term care facility and provide continuous nursing care services.)

For recipients residing in a skilled nursing or intermediate care facility and who are out of the facility due to inpatient hospitalization or home visitation, payment for bed reservation days for each day the patient is out of the facility will be made in addition to the payment for routine home care, continuous nursing care or general inpatient care, whichever is applicable. (In the

case where the patient is away from the long term care facility for home visitation, the hospice agency must continue to provide the patient's care.) Payment for bed reservation days will be limited to a maximum of 14 consecutive days and a total of 45 days per lifetime per recipient for inpatient hospitalization and a maximum of 15 days per lifetime per recipient for home visitation. Payment for any days in excess of these limitations will be disallowed.

Payment by the KMAP will constitute reimbursement in full and will relieve the Program and the recipient of further liability.

All providers must make fair and equal charges for every person served and in no case may charges for Program recipients or payment on their behalf exceed charges to other patients for the same or similar service.

D. Reimbursement in Relation to Medicare

Recipients who are eligible for both Medicare and Medicaid and who are receiving hospice benefits through the Medicare program may elect to have the five percent co-payment for drugs and respite care reimbursed by the KMAP.

[~~The days for which the Medicaid co-payment is requested will be applied against the total number of Medicaid Hospice days. This will apply to both the respite care days and the number of days covered by the drugs and biologicals.~~]

The co-payment reimbursement will be a maximum of 5% per prescription cost of the drug and/or biological and 5% of the payment made by HCFA for a respite care day but may not exceed $5.00 per day for respite or $5.00 per prescription.

A copy of the Medicare EOMB must be attached to the UB-82 as well as the invoice for the drugs and/or biologicals to which the five percent co-payment is applied. (Please refer to Section VIII C for billing instructions.)

All forms and enrollment procedures (see Section V for eligibility requirements and Section VIII for completion of forms) which apply to clients who have Medicaid only also apply to clients with both Medicare and Medicaid.

Recipients identified as Qualified Medicare Beneficiaries (QMB) only are eligible only for co-payment for drugs and respite care.

E. Other Third Party Coverage

The 1967 amendments to the Social Security Law stipulate that Title XIX programs have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of the expenses of the services rendered, that party is primarily liable for the patient's expenses. The KMAP has secondary liability. Accordingly, the provider of service should first seek reimbursement from such third party group. If you as the provider should receive payment from the KMAP before knowing of the third party's liability, a refund of the payment amount should be made to the "Kentucky State Treasurer" and mailed to EDS, P.O. Box 2009, Frankfort, Kentucky 40602, Attention: Cash/Finance Unit. The amount payable by the Cabinet shall be reduced by the amount of the third party obligations.

1. Identification of Third Party Resources

Pursuant to KRS 205.662, prior to billing the Kentucky Medical Assistance Program all participating vendors shall submit billings for medical services to a third party when such vendor has prior knowledge that such third party may be liable for payment of the services.

In order to identify those recipients who may be covered through a variety of health insurance resources, the provider should inquire if the recipient meets any of the following conditions:

-If the recipient is married or working, inquire about possible health insurance through the recipient's or spouse's employer;
-If the recipient is a minor, ask about insurance the MOTHER, FATHER, or GUARDIAN may carry on the recipient;

-In cases of active or retired military personnel, request information about CHAMPUS coverage and social security number of the policy holder;
-For people over 65 or disabled, seek a MEDICARE HIC number;
-Ask if the recipient has health insurance such as a MEDICARE SUPPLEMENT policy, CANCER, ACCIDENT,or INDEMNITY policy, GROUP health or INDIVIDUAL insurance, etc.

Examine the recipient's MAID card for an insurance code. If a code indicates insurance coverage, question the recipient further regarding the insurance.

2. Billing Instructions for Claims Involving Third Party Resources

If the patient has third party resources, then the provider must obtain payment or rejection from the third party before Medicaid can be filed. When payment is received, the provider should indicate on the claim form in the appropriate field the amount of the third party payment and the name and policy numbers of health insurance covering the recipient. If the third party rejected the claim, a copy of the rejection notice must be attached to the Medicaid claim.

Exceptions:

*If the other insurance company has not made payment within 120 days of date of filing a claim to the insurance company, submit with the Medicaid claim a copy of the other insurance claim to EDS indicating "NO RESPONSE" on the Medicaid claim form. Then forward a completed TPL Lead form to:

EDS
P.O. Box 2009
Frankfort, KY 40602
Attn: TPL Unit

*If proof of denial for the same recipient for the same or related services from the carrier is attached to the Medicaid billing, claims processing can proceed. The denial cannot be more than six months old.

*A letter from the provider indicating that he/she contacted XYZ insurance company and spoke with an agent to verify that the recipient was not covered, can also be attached to the Medicaid claim.

3. Medicaid Payment for Claims Involving a Third Party

Claims meeting the requirements for KMAP payment will be paid in the following manner if a third party payment is identified on the claim.

The amount paid by the third party will be deducted from the Medicaid allowed amount and the difference paid to the provider. If the third party payment amount exceeds the Medicaid allowed amount, the resulting KMAP payment will be zero. Recipients cannot be billed for any difference between the billed amount and Medicaid payment amount. Providers must accept Medicaid payment as payment in full.

Claims for services involving a private insurace company that has made a payment to the recipient can only be paid the difference between the allowable Medicaid rate and the insurance amount paid. The amount paid is to be entered in the appropriate block to enable the claim to pay.

The TPL Lead Form is used in cases where no response has been received from the insurance company and 120 days have elapsed since the submission of the claim. In that case, the claim will be paid at the Medicaid allowable rate and EDS will then pursue collection from the company. An example of the TPL Lead Form may be found in the Appendix Section of this manual, Appendix XV.

If the claims for a recipient are payable by a third party resource which was not pursued by the provider, the claim will be denied. Along with a Third Party insurance denial explanation, the name and address of the insurance company, the name of the policy holder, and the policy number will be indicated. The provider must pursue payment with this third party resource before billing Medicaid again.

If you have any questions, please write to EDS, P.O. Box 2009, Frankfort, Kentucky 40602, Attention: Third Party Unit, or call (800) 333-2188[~~372-2921~~].

F. Client's Continuing Income Liability

If it is determined by the local office of the Department for Social Insurance that a client has income in excess of the monthly eligibility standard, the amount of excess income is to be paid to the provider by the recipient or responsible party and shall be deducted from the Title XIX payments. Notification of the amount of excess income shall be forwarded to the Hospice provider from the Department for Medicaid Services on Form MAP-552. (See Appendix XVI) It is the responsibility of the provider to collect this money from the client.

Providers should continue to bill all covered Hospice services received by the client to the KMAP.

The applicable continuing income will be pro-rated and deducted from Medicaid payments on a per diem basis.

G. Spend Down

Spend down is defined as the utilization of excess income for recognized medical expenses. If a client has income greater than that which is usually permitted for Medicaid eligibility, the local office of the Department for Social Insurance, using a standard computation formula, determines the excess income for a three month period. This quarterly excess is the spend-down amount which must be applied toward incurred or paid medical expenses. The medical card becomes effective on the date on which the quarterly excess income amount is met. Spend down eligibility may be determined for a period three months prior to the application or for a three month period after the application. An MA spend-down eligibility card is a time limited card and requires re-application quarterly.

H. Special Income Provisions

Special income provisions are allowed for Medicaid eligibility for all Hospice clients who are either married or under age eighteen (18). The income and resources of the spouse or parents will be considered available to the Hospice client for the month of admission only.

SECTION VII - REIMBURSEMENT

For the second month and each succeeding month of Hospice participation, only the income and resources of the Hospice client will be used to determine Medicaid eligibility. Additionally, all Hospice clients will be allowed to retain from their own income for their basic maintenance needs an amount equal to the SSI basic benefit rate plus the SSI general disregard.

I. Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by the KMAP, whether due to erroneous billing or payment system faults, must be refunded to the KMAP. Refund checks should be made payable to "Kentucky State Treasurer" and sent immediately to:

EDS
P.O. Box 2009
Frankfort, KY 40602

ATTN: Cash/Finance Unit

Failure to refund a duplicate or inappropriate payment could be interpreted as fraud or abuse, and prosecuted as such.

SECTION VIII - COMPLETION OF FORMS

VIII. COMPLETION OF FORMS

A. General

The Uniform Billing Statement (UB-82) is to be used for billing Hospice services rendered to eligible KMAP recipients. A copy of this form may be found in Appendix V of this manual.

A separate billing form is to be used for each patient.

UB-82 billing forms may be obtained from the Kentucky Hospital Association.

IMPORTANT: The recipient's Kentucky Medical Assistance Identification Card should be carefully checked to see that the recipient's name appears on the card and that the card is valid for the period of time in which the medical services are to be rendered and the election of hospice benefits is in effect. You cannot be paid for services rendered to an ineligible person.

The original of the invoice set should be mailed to:

EDS
P.O. Box 2045
Frankfort, Kentucky 40602

B. Completion of UB-82 MEDICAID ONLY

Following are instructions in form locator order for billing Medicaid services on the UB-82 billing statement (completion of UB-82 for Medicare/Medicaid copayment is found in Section VIII C of this manual). Only instructions for form locators required for EDS processing or KMAP information are included. Instructions for form locators not used by EDS/KMAP processing may be found in the UB-82 Training Manual. The UB-82 Training Manual may be obtained from the Kentucky Hospital Association.

SECTION VIII - COMPLETION OF FORMS

FORM LOCATOR[~~Form Locator~~]

1 PROVIDER NAME AND ADDRESS[~~PROVIDER NAME AND ADDRESS~~]

Enter the complete name and address of the institution.

3 PATIENT CONTROL NUMBER[~~PATIENT CONTROL NUMBER~~]

Enter the patient control number. The first 7 digits will appear on the Remittance Advice.

4 TYPE OF BILL[~~TYPE OF BILL~~]

Enter the applicable 3 digit code that describes type of bill.

1st Digit (Type Facility): 8 = Hospice

2nd Digit (Bill Class):
1 Hospice (Non Hospital Based)
2 Hospice (Hospital Based)

3rd Digit (Frequency):
1 = Admit through discharge claim
2 = Initial billing
3 = Interim billing
4 = Final billing

8 MEDICAID PROVIDER NUMBER[~~MEDICAID PROVIDER NUMBER~~]

Enter the Hospice Agency's 8 digit Kentucky Medicaid Provider number.

10 PATIENT NAME[~~PATIENT NAME~~]

Enter the name of the recipient in last name/first name sequence as shown on his/her current Medical Assistance Identification (MAID) card.

15 DATE OF ADMISSION[~~DATE OF ADMISSION~~]

Enter the date on which the recipient was admitted to the hospice in month, day, year sequence and in numeric format (e.g., 01/03/86).

SECTION VIII - COMPLETION OF FORMS

FORM LOCATOR[~~Form Locator~~]

21 PATIENT STATUS CODE[~~PATIENT STATUS CODE~~]

Enter the applicable 2 digit patient status code as of the through date of the billing period.

Code Structure

01 - Discharge (left care of this hospice)
30 - Still patient of this hospice
40 - Died at home
41 - Died in a medical facility, such as a hospital, SNF, ICF, or Free Standing Hospice
42 - Place of death unknown

22 STATEMENT COVERS PERIOD[~~STATEMENT COVERS PERIOD~~]

From - Enter the beginning date of the billing period covered by this invoice in month, day, year sequence and in numeric format.

Through - Enter the last date of the billing period covered by this invoice in month, day, year sequence and in numeric format.

Do not show days before patient's Medicaid election period began.

28 OCCURRENCE CODE[~~OCCURENCE CODE~~]

Enter the 2 digit code that indicates whether the illness was employment or accident related.

Code Structure UB82 Manual

01 Auto Accident
02 Auto Accident/No Fault Insurance Involved
03 Accident/Last Liability
04 Employment Related Accident or Illness
05 Other Accident

SECTION VIII - COMPLETION OF FORMS

FORM LOCATOR[~~Form Locator~~]

50 DESCRIPTION[~~DESCRIPTION~~]

Enter a from and through date (within this billing period) in numeric format and in month, day and year sequence for each revenue code shown on the same line in Column 51. PLEASE ENTER SERVICE DATES WITHIN ONE MONTH ONLY ON EACH LINE except in the case of respite care. The entire inpatient respite care stay MUST be entered on ONE line. NOTE: Please complete no more than ten lines per billing statement.

51 REVENUE CODE[~~REVENUE CODE~~]

Enter the 3 digit revenue code for the service being billed (A LIST OF THE REVENUE CODES ACCEPTED BY KMAP CAN BE FOUND ON PAGES 7.1 AND 7.2 OF THIS MANUAL. Also, see special instructions for billing certain revenue codes on page 8.6 of the manual). Revenue code 001 (Total Charges) must be the last revenue code listed.

52 UNITS[~~UNITS~~]

Enter the number of units for each service billed. Units are measured in days for code 653, 182, 183, 184, 185, 654, 651, 655, and 656, in hours for code 652, and in number of prescription drugs for 250. Units for Medicare co-payment are measured in days for 658 and in number of prescriptions for 659.

53 TOTAL CHARGES[~~TOTAL CHARGES~~]

Enter the total charges for each revenue code on the same line in column 53. The last revenue code entered in column 51 (001) represents the total of all charges billed, and that total should be the last entry in column 53.

57 PAYER[~~PAYER~~]

Enter the name of each payer (e.g. Medicare, Private Insurance, etc.) from which the provider might expect payment.

SECTION VIII - COMPLETION OF FORMS

FORM LOCATOR[~~Form Locator~~]

63 PRIOR PAYMENTS[~~PRIOR PAYMENTS~~]

Enter the total amount (if any) received from private insurance (the amount should be listed on the corresponding line with the payer in #57). NEITHER Medicare payment amount, Medicaid payment amount, nor the recipient continuing income amount is to be entered.

65 INSURED'S NAME[~~INSURED'S NAME~~] - REQUIRED ENTRY

Enter the name of the recipient in last name/first name sequence as shown on his/her current MAID card.

68 MEDICAL ASSISTANCE ID NUMBER [~~MEDICAL ASSISTANCE ID NUMBER~~]

Enter the recipient's 10 digit identification number EXACTLY as shown on his/her current MAID card.

77 PRIMARY DIAGNOSIS CODE[~~PRIMARY DIAGNOSIS CODE~~]

Enter the ICD-9 diagnosis code for which the patient is receiving treatment.

78 THRU 81 OTHER DIAGNOSIS CODES[~~OTHER DIAGNOSIS CODES~~]

Enter other ICD-9 diagnosis codes (if any) for which the patient is receiving treatment.

92 ATTENDING PHYSICIAN ID[~~ATTENDING PHYSICIAN ID~~]

Enter the 5 digit license number of the attending physician.

SECTION VIII - COMPLETION OF FORMS

FORM LOCATOR[~~Form Locator~~]

95 PROVIDER CERTIFICATION[~~PROVIDER CERTIFICATION~~] - Required

Enter the actual signature (not a facsimile) of the invoicing provider or the provider's duly appointed representative. STAMPED SIGNATURES ARE NOT ACCEPTED.

96 INVOICE DATE[~~INVOICE DATE~~]

Enter the date in month, day, year sequence and in numeric format on which this invoice was signed and submitted to EDS for processing.

SPECIAL INSTRUCTIONS FOR SPECIFIC REVENUE CODES

653 Room and Board SNF - Charges for room and board must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 653[~~160~~] must be billed with either 651 (Routine Home Care) or 652 (Continuous Nursing Care).

654 Room and Board ICF - Charges for room and board must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 654[~~220~~] must be billed with either 651 (Routine Home Care) or 652 (Continuous Nursing Care).

182 ICF Bed Reservation Days Home - Charges for ICF bed reservation days must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 182 must be billed with either 651 (Routine Home Care) or 652 (Continuous Nursing Care).

183 SNF Bed Reservation Days Home - Charges for SNF bed reservation days must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 183 must be billed with either 651 (Routine Home Care) or 652 (Continuous Nursing Care).

184 ICF Bed Reservation Days Hospital - Charges for ICF bed reservation days must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 184 must be billed with 656 (General Inpatient Care).

185 SNF Bed Reservation Days Hospital - Charges for SNF bed reservation days must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 185 must be billed with 656 (General Inpatient Care).

655 Inpatient Respite Care - The entire inpatient respite care MUST[~~must~~] be entered on one line.

NOTE: Claims with services dates more than twelve (12) months old can be considered for processing ONLY [~~only~~] with appropriate documentation such as one or more of the following: Remittance statements no more than 12 months of age which verify timely filing, backdated MAID cards (the words "backdated card" should be written on the claim form and on the copy of the backdated MAID card), Social Security documents, correspondence describing extenuating circumstances, Return to Provider Letters, Medicare EOMB's etc. Without such documentation, claims over 12 months old will be denied.

C. Completion of UB-82 for Medicare Co-Payment

Following are instructions for billing the Medicare co-payment on the UB-82 billing statement. All form locators should be completed as outlined in Section VIII B of this manual with the following exceptions.

FORM LOCATOR[~~Form Locator~~]

50 DESCRIPTION[~~DESCRIPTION~~]

Enter a from and to date (within this billing period) in numeric format and in month, day and year sequence for each revenue code shown on the same line in Column 51. The line item dates of service for the prescription co-payment must reflect the from and to days covered by the prescription.

51 REVENUE CODE[~~REVENUE CODE~~]

Enter the 3 digit revenue code for the service being billed.

1. Respite Care Co-Payment
   a. Revenue Code: 658
   b. Unit of Service: 1 day (24 hours)

2. Hospice Drug Co-Payment
   a. Revenue Code: 659
   b. Unit of Service: 1 prescription = 1 unit

52 UNITS[~~UNITS~~]

Enter the number of units for each service billed. Units are measured in days for code 658 and in number of prescription for 659. Since Medicare does not allow payment for more than five (5) consecutive days of respite care, DO NOT[~~do not~~] bill for more than five (5) units for 658. Note: In the case of co-payment for drugs, the number of units will not always equal the number of days covered in the date span for the service.

A copy of the applicable Explanation of Medicare Benefits (EOMB) and a drug invoice (when applicable) must be attached to the UB-82. It is not necessary to attach a copy of the EOMB if only charges for room and board are being billed.

All other pertinent criteria for hospice coverage must be met.

NOTE: For patients with both Medicare and Medicaid, when billing for service dates which include charges for co-payments (drug and/or respite) and room and board or board reservation days all charges should be billed on the same UB-82. If no co-payment is being billed, charges for room and board and/or bed reservation days may be billed alone.

SECTION VIII - COMPLETION OF FORMS

D. Completion of Election of Medicaid Hospice Benefit Form (MAP-374)

An individual who meets the eligibility requirements for hospice care and elects to receive that care, must file an Election of Medicaid Hospice Benefits Form (MAP-374) with the particular hospice agency who will be providing the care.

The name of the individual, the MAID number, the name and provider number of the hospice agency and the effective date that hospice care begins must be entered in the appropriate spaces on the MAP-374, as well as the name of the agency who will be providing outpatient medication.

The effective date for the election period may begin with the first day of hospice care or any subsequent day of hospice care. The effective date may not be prior to the date that the election is made.

The election to receive hospice care will be considered to continue [~~through the initial and subsequent election periods~~] as long as the individual remains in the care of the hospice and does not revoke the election of hospice benefits. [~~The two ninety day election periods must be used before the thirty day period.~~] The MAP-374 will remain in effect for the duration of hospice care.

The section of the MAP-374 regarding Medicare eligibility must be completed appropriately and if Medicare eligible, the dates of Medicare eligibility must be entered. NOTE: If an individual is not eligible for Medicare benefits at the time the Medicaid hospice benefit begins but begins [~~exhausts~~] his/her Medicare benefits during the Medicaid benefit period, the hospice agency should send a Hospice Patient Status Change Form (MAP-403) [~~photocopy of the original MAP-374~~] to the Department for Medicaid Services and the local Department for Social Insurance Office indicating [~~on the photocopy~~] the date that Medicare benefits became effective [~~were exhausted~~]. [~~The information should be entered on the second page of the MAP-374 below the third certification period section. The individual (or authorized representative) should sign the form following the statement of Medicare ineligibility.~~] Failure to submit this information will result in incorrect payment of claims [~~since without the information the individual would still be considered Medicare eligible and restricted only to co-payment and/or room and board benefits rather than the full Medicaid hospice benefit~~].

The section of the MAP-374 pertaining to long term care facility residents must be completed if the patient is a resident in a long term care facility at the time he/she elects the Medicaid hospice benefit. The name of the facility and the type of facility (skilled nursing or intermediate care) must be entered. If a patient enters a long term care facility during the Medicaid hospice benefit period, the hospice agency should send a Hospice Patient Status Change Form (MAP-403) [~~photocopy of the original MAP-374~~] to the Department for Medicaid Services and to the local

Department for Social Insurance Office indicating the name and type of the facility in the appropriate space and the date on which the patient was admitted to the facility. Failure to submit this information could result in the incorrect determination of the patient's eligibility.

The MAP-374 must be signed and dated by the individual (or authorized representative) and a witness.

If an individual revokes the election of hospice benefits [~~during the first election period~~] and later elects to receive hospice benefits again, the second certification section of the MAP-374 must be completed with the signature of the individual (or authorized representative) and a witness, as well as the effective date that the second election period will begin. Requirements for the second election period are the same as those for the initial election period. If an individual revokes the election of hospice benefits during the second election period and later elects to receive hospice benefits again, the third certification section of the MAP-374 must be completed with the signature of the individual (or authorized representative) and a witness, as well as the effective date that the third election period begins. Requirements for the third election period are the same as those for the initial and second election periods.

The second and third certification sections of the MAP-374 need not be completed if the previous benefit has not been revoked.

A copy of the MAP-374 MUST be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the effective date of the election period. A copy must also be retained by the hospice agency.

Failure to complete forms correctly may result in delays in payment.

An example of the MAP-374 may be found in the Appendix Section of this manual, Appendix VI [~~II~~].

SECTION VIII - COMPLETION OF FORMS

E. Completion of Revocation of Medicaid Hospice Benefit Form (MAP-375)

If an individual chooses to revoke his/her Medicaid hospice benefits, he/she must file a Revocation of Medicaid Hospice Benefits Form (MAP-375) with the particular hospice agency who has been providing the hospice care.

The name of the individual, the MAID number, and the name and provider number of the hospice agency must be entered in the appropriate spaces on the MAP-375, as well as the effective date that the revocation begins and the individual resumes his/her regular Medicaid coverage. The effective date of the revocation may not be prior to the date that the revocation is made.

The MAP-375 must be signed and dated by the individual (or authorized representative) as well as a witness. Additionally, the hospice agency staff should complete the Rationale of Revocation section of the MAP-375.

A copy of the MAP-375 MUST be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the effective date of the revocation. A copy must also be retained by the hospice agency.

Failure to complete forms correctly may result in delays in payment.

An example of the MAP-375 may be found in the Appendix Section of this manual, Appendix VII [~~I~~].

SECTION VIII - COMPLETION OF FORMS

F. Completion of Change of Hospice Providers Form (MAP-376)

If an individual chooses to change from one hospice agency to another for hospice care, he/she must file a Change of Hospice Providers Form (MAP-376) with both the hospice agency which has been providing care and the hospice agency which will begin providing care.

The name of the individual, the MAID number, the name and provider number of both hospice agencies and the effective date that the change of providers begins must be entered in the appropriate spaces on the MAP-376. (NOTE: A change in hospice providers is NOT a revocation of hospice benefits.)

The MAP-376 must be signed and dated by the individual (or authorized representative) and a witness. [~~A change of hospice providers may occur only once during an election period~~.]

A copy of the MAP-376 MUST be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the effective date of the change. A copy must also be retained by each hospice agency.

A copy of the original MAP-374 should be sent to the new hospice agency along with the Change of Hospice Providers Form (MAP-376).

Failure to complete forms correctly may result in delays in payment.

An example of the Change of Hospice Providers Form (MAP-376) may be found in the Appendix Section of this manual, Appendix VIII [~~IX~~].

SECTION VIII - COMPLETION OF FORMS

G[~~H~~] Completion of Termination of Medicaid Hospice Benefits Form (MAP-378)

If hospice benefits for an individual are terminated for any reason, a Termination of Medicaid Hospice Benefits Form (MAP-378) must be filed by the hospice agency which has been providing hospice care.

The name of the individual, the MAID number, the effective date of the termination and the name and provider number of the hospice agency must be entered in the appropriate spaces on the MAP-378.

The block which indicates the reason for termination must be checked. If patient is deceased, the date of death must be entered. If "Other" is checked an explanation of the reason for termination must be included.

This form may [~~is~~] also [~~to~~] be used if a patient becomes inactive. The date the patient became inactive must be entered, and the block "Condition Improved, Patient in Long Term Inactive Status" must be checked. [~~"Other" must be checked and "inactive status" must be entered in the "Other" area.~~]

(NOTE: Termination of hospice benefits is NOT a revocation of benefits.)

The MAP-378 must be signed and dated by the hospice medical director.

A copy of the MAP-378 MUST be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the effective date of the termination. A copy must also be retained by the hospice agency.

An example of the MAP-378 may be found in the Appendix Section of this manual, Appendix X [~~XI~~].

[G. ~~Completion of Request for Extension of Medicaid Hospice Benefits Form (MAP-377, MAP-377A)~~

~~If an individual has used both ninety-day~~ election periods ~~and the thirty-day election period and wishes to extend hospice coverage, the individual must file a Request for Extension of Medicaid Hospice Benefits Form (MAP-377, MAP-377A) with the hospice agency from whom he/she is receiving care~~.

~~The name of the individual, the MAID number, the name of the hospice agency, the effective date that the extension of coverage begins and the end date of the extension period must be entered in the appropriate spaces on the first page of the MAP-377~~.

~~The second page, the MAP-377A, must be completed by the hospice medical director. The name of the medical director, the name of the hospice agency, and the effective date that the extension period begins must be entered in the appropriate spaces~~.

~~The MAP-377 must be signed and dated by the hospice medical director~~.

~~The MAP-377 is not to be completed unless the individual requests an extension of benefits~~.

~~A copy of the MAP-377, MAP-377A must be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the effective date of the extension period. A copy must also be retained by the hospice agency~~.

~~Failure to complete forms correctly may result in delays in payment~~.

~~An example of the MAP-377, MAP-377A may be found in the Appendix Section of this manual, Appendix X.~~]

SECTION VIII - COMPLETION OF FORMS

H[~~I~~]. Completion of Representative Statement For Election of Hospice Benefits (MAP-379)

If an individual is unable, due to physical and/or mental incapacity, to act on his/her own behalf, a legal representative may be appointed. The legal representative may sign any or all hospice forms on behalf of the individual. The name of the representative and the name of the individual and the MAID number must be entered in the appropriate spaces on the MAP-379.

The MAP-379 must be signed and dated by the legal representative and a witness.

The MAP-379 need only be completed once, at the time the representative begins acting on behalf of the individual; a copy of the completed MAP-379 must, however, accompany all other forms which the legal representative has signed on behalf of the individual.

A copy of the MAP-379 MUST be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the date when the representative begins acting on behalf of the individual. A copy must also be retained by the hospice agency.

Failure to complete forms correctly may result in delays in payment.

An example of the MAP-379 may be found in the Appendix Section of this manual, Appendix XI[~~I~~].

I[~~J~~]. Completion of the Other Hospitalization Statement (MAP-383)

If a hospice recipient is hospitalized for any condition not related to the terminal illness, an Other Hospitalization Statement (MAP-383) must be completed. The name of the hospital to which the recipient is being admitted, the name and MAID number of the recipient and the actual date of the hospital admission should be entered in the appropriate spaces. The Diagnosis and the ICD 9 CM code for this hospitalization must be entered. The Diagnosis and the ICD 9 CM

code for the patient's terminal illness must be entered. The appropriate block regarding previous hospitalizations must be checked and the dates, diagnoses and ICD 9 CM codes for previous admissions must be entered when applicable. The form must be signed and dated by the medical director of the hospice. The form should be sent to the KMAP for review along with documentation which includes the terminal diagnosis, the patient's present condition and verification that the reason for this hospitalization is in NO way related to the terminal illness. After review by the KMAP, the form will be returned to the hospice agency marked "Approved by the KMAP" or "Denied by the KMAP" and signed by a KMAP representative. If approved, one copy should be sent to the admitting hospital and one copy should be retained by the hospice agency. Hospice services may not be billed during the period of hospitalization. If denied, the hospice agency must bill for the service using the revenue code for General Inpatient Care.

An example of the Other Hospitalization Statement (MAP-383) may be found in Appendix XVII of this manual.

J[~~K.~~].Completion of Hospice Drug Form (MAP-384)

If a hospice recipient requires drugs which are not related to his/her terminal illness, a Hospice Drug Form (MAP-384) must be completed and submitted to the KMAP with the Election of Benefits Form (MAP-374). Instructions for completion of the form are as follows:

BLOCK
NO.

1 RECIPIENT LAST NAME

Enter the last name of the recipient

2 FIRST NAME

Enter the first name of the recipient

3 MEDICAL ASSISTANCE I.D. NUMBER

Enter the recipient's MAID Number exactly as it appears on his/her current MAID card.

4 DATE MEDICAID HOSPICE COVERAGE BEGAN

Enter the actual date Medicaid hospice coverage for this recipient began. The date must agree with the effective date of the Election of Benefits Form (MAP-374).

5 FIRST DIAGNOSIS (Not Related to the Terminal Illness)

Enter the diagnosis for the condition which requires the prescriptions; enter the ICD-9-CM code for the diagnosis.

SECOND DIAGNOSIS (Not Related to the Terminal Illness)

Enter the second diagnosis (if any) for the condition which requires the prescription; enter the ICD-9-CM code for the diagnosis.

6. TOTAL NUMBER OF PRESCRIPTIONS NOT RELATED TO TERMINAL ILLNESS

Enter the total number of prescriptions not related to the terminal illness.

7 DRUG NAME

Enter the name and strength (10 mg. 100 mg.) of the drug

8 NDC

Enter the NDC for the drug

9 UNITS

Enter the number of units required

10 PRICE PER UNIT

Enter the actual price per unit

11 TOTAL CHARGE

Enter the total charge for this prescription

12 MEDICAID MAXIMUM ALLOWABLE

Leave Blank

13 TOTAL UNITS THIS INVOICE

Enter the total number of prescriptions requested on this invoice

14 TOTAL CHARGE THIS INVOICE

Enter the total charge for all prescriptions requested on this invoice

15 TERMINAL DIAGNOSIS

Enter the terminal diagnosis of the patient and the ICD 9 CM code for that diagnosis.

16 PREVIOUSLY REQUIRED PRESCRIPTIONS

Enter whether the patient required these prescriptions prior to the diagnosis of the terminal illness.

17 PRESCRIPTIONS RESULTING FROM HOSPITALIZATION

Enter whether the prescriptions are the result of a hospitalization not related to the terminal illness.

18 DATES OF HOSPITALIZATION

If "yes" is checked in block 17, enter the dates of that hospitalization.

19 NAME OF HOSPITAL

If "yes" is checked in block 17, enter the name of the hospital.

SECTION VIII - COMPLETION OF FORMS

20 PRESCRIBING PHYSICIAN

Enter the name of the physician prescribing these drugs.

21[~~15~~] PROVIDER CERTIFICATION AND SIGNATURE

The actual signature of the provider (not a facsimile) or the provider's authorized agent is required

22[~~16~~] PROVIDER NAME AND ADDRESS

Enter the complete name and address of the hospice agency

23[~~17~~] PROVIDER NUMBER

Enter the 8 digit Medicaid provider number of the hospice agency. The number must begin with "44."

24[~~18~~] INVOICE DATE

Enter the date on which this invoice was signed and submitted to the KMAP.

25[~~19~~] INVOICE NUMBER

No entry required

Both copies of the MAP-384 should be attached to the Election of Benefits Form (MAP-374). Documentation must also be attached which verifies that the need for these prescriptions/items is in NO way related to the patient's terminal illness. One copy will be returned to the provider by the KMAP with the allowable maximum Medicaid payment entered in Block 12 for each prescription. If payment is not allowed, "NA" will be entered in Block 12.

Only one MAP-384 need be submitted unless the hospice benefit is revoked or unless there is a change in the prescriptions required. The initial MAP-384 should be submitted with the recipient's Election of Benefit Form (MAP-374). If the hospice benefit is revoked and then reinstated, a new MAP-384 should be sent with the second or third certification period. If there is a change in the prescriptions required, an MAP-384 only should be submitted. The hospice agency should retain a copy of the invoice.

The MAP-384 should also be used when requesting prior approval for additional payment for nutritional supplements when they are required for the total nutrition of the patient. The form should be completed as for regular prescriptions with the name of the nutritional supplement entered in block 7 and the NDC number entered in block 8. Documentation from the attending physician which verifies that the nutritional supplements are required for the patient's total nutrition must be attached to the MAP-384.

An example of the MAP-384 may be found in Appendix XVIII of this manual.

K[~~L~~]. Completion of Other Services Statement (MAP-397)

For those services which are usually covered under the hospice benefit but are being billed separately because they have been determined to be totally unrelated to the terminal illness of the patient, an Other Services Statement (MAP-397) must be completed in order to obtain approval from the KMAP. Instructions for completion of the form are as follows:

1. The name of the agency providing the service, the name and MAID number of the recipient and the date of service must be entered in the appropriate spaces.

2. The diagnosis of the condition requiring this service and the ICD 9 CM code for that diagnosis must be entered.

3. The diagnosis and ICD 9 CM code of the patient's terminal illness must be entered.

4[~~2~~]. Items of durable medical equipment being billed separately must be specifically identified.

5[~~3~~]. A description of hospital outpatient services and the reason for the services must be entered.

6[~~4~~]. The form must be signed and dated by the medical director of the hospice agency.

7[~~5~~]. Documentation which verifies that the services are totally unrelated to the terminal illness of the patient must be attached to the form.

SECTION VIII - COMPLETION OF FORMS

8[~~6~~]. All copies of the form should be submitted to the Department for Medicaid Services, Division of Policy and Provider Services. Two copies of the form will be returned to the provider signed by a KMAP representative [~~by the KMAP~~] indicating whether separate payment for the services has been approved or denied.

9[~~7~~]. If approved, one copy of the form should be sent to the provider who will bill for the service. The other copy should be retained by the hospice agency.

An example of the Other Services Statement (MAP-397) may be found in Appendix XIX of this manual.

SECTION VIII - COMPLETION OF FORMS

L. Completion of Hospice Patient Status Change Form (MAP-403)

This form should be used any time a patient's status changes in any way after the Election of Medicaid Benefits Form (MAP-374) is filed.

Enter the patient's name and MAID number.

Enter the name and provider number of the hospice agency.

Enter the original date of election of Medicaid hospice benefits.

Enter the effective date of this change.

Check the block which appropriately describes this change and all information pertaining to the change.

The form must be signed by the patient or his/her authorized representative and a Hospice Agency Representative.

A copy of the MAP-403 must be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the effective date of the change. A copy must also be retained by the hospice agency.

Failure to complete the form correctly may result in delays in payment.

An example of the MAP-403 may be found in the Appendix Section of this manual, Appendix IX.